Almost Home

Reforming Home and Community Care in Ontario

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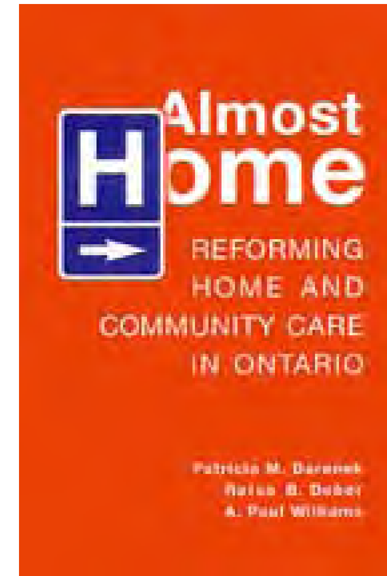

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Reform Context

Home and community reform efforts of:

Peterson Liberal Government (1985-87, 1987- 90)

Rae NDP Government (1990 – 1995)

Harris PC Government (1995 – 2000)

Home and Community Care:
1980's Context

The role of the state is under debate – rise of debts and deficits call for retrenchment; rise of a neo conservative agenda; and globalization of economies through free trade agreements.

Governments were looking at home and community care to ease pressures on health care budgets due to:

- an aging population
- the high cost of hospital and facility care.

At the same time the home was becoming the site of care because of

- new technologies and pharmaceuticals that enabled seniors to live more independently and safely in the community, and
- enabled hospitals to shorten patients' lengths of stay

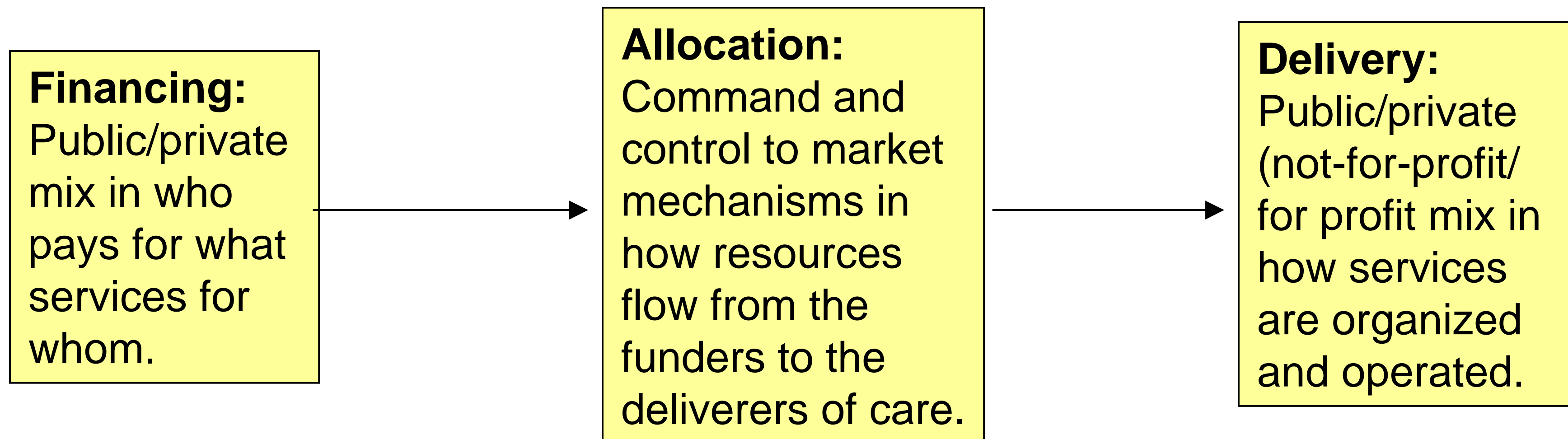
The broader determinants of health were seen as having an equal, if not greater role, in promoting health and preventing disease than the health care system.

Reasons for reform of the sector included:

- Proliferation of one-off services
- little coordination and integration
- split in government responsibilities resulting in different eligibility criteria, funding criteria, different value systems
- difficulty to access and navigate "system"
- geographic inequities in services

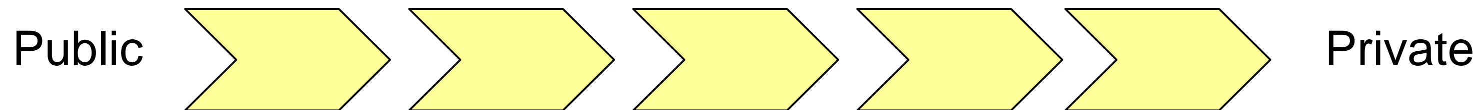
Policy *Content* of Reforms

The policy choices and trade-offs made by each successive government in establishing the appropriate roles and responsibilities of the public and private sector were examined. In particular, three policy dimensions were explored:



Financing Policy Choices

Privatization by Stealth – financing shifts towards the private end of the continuum.



- In terms of financing during the period we analyze (1985 to 1999) we witnessed the disentitlement of home care as governments proposed and finally moved the funding of home care out of the OHIP budget into a capped budget, and introduced service limits.
- Although home care was and is not protected under the Canada Health Act, the Ontario government had basically made it an entitled service by placing it in the OHIP budget.
- However, with the shift into a capped budget, care would be fully funded when provided but it would not necessarily be provided when needed.
- PC government introduced stricter service eligibility criteria (acute care clients given priority over chronic care clients) and service limits
- Although this aspect of the reform received little attention at the time, it provided the opportunity for governments to privatize Medicare by stealth.

Delivery Policy Choices

Delivery shifts back and forth from not-for-profit to for-profit	
Liberals	
One-Stop (1987)	Public ← → Private
Service Access Organization (1990)	Public ← → Private
NDP	
Service Coord. Agency (1991)	Public ← → Private
Multi-Service Agency (1993)	Public ← → Private
Progressive Conservatives	
Community Care Access Centre (1996)	Public ← → Private

Allocation Policy Choices

Allocation shifts from brokerage, to command and control (C&C), to more market mechanisms of competitive contracting.

Liberals		
One-Stop (1987)	C&C	market
Service Access Organization (1990)	C&C	market
NDP		
Service Coord. Agency (1991)	C&C	market
Multi-Service Agency (1993)	C&C	market
Progressive Conservatives		
Community Care Access Centre (1996)	C&C	market

Policy Process: Role of Ideas, Interests, & Institutions

or

Why did policy dimensions of reform shift across governments?

- Unlike the main stream of health care – the physician and hospital sector - which is institutionalized in legislation and resistant to dramatic change, reform efforts of home and community care swung with each change in government.

- Despite the fact that the NDP introduced and passed legislation creating the Multi-Service agencies, a quasi public model, the Conservative Harris government was able to introduce and implement the pro-market model of the community care access centres.

- The nature and structure of the policy community and the institutions surrounding the decision making in this sector were examined to explain why each government was able to design a model that reflected its own ideology despite considerable objection by different parties in the wider policy community.

- The policy community, outside of government, was comprised of a large number of loosely organized and fragmented groups that included:
  - consumer groups such as the elderly, the disability community, the ethnic and religious communities;
  - the provider groups, which included health and social support providers, for-profit and not-for-profit providers; and
  - various labour and volunteer groups.

- Despite the efforts of these stakeholders, the State was able to seize control of the agenda. Coalitions of stakeholders were created in an attempt to influence reform. However, they were unable to sustain their mutual interests long enough to have a strong voice in reform as each change in government introduced a shift in the balance of power in the policy community, leading to the dissolution of former coalitions and the formation of new ones.

- The instability of this policy sector stands in stark contrast to the stability of the Medicare mainstream.

Government Ideas & Interests Predominate

- weak network of societal interests
- no constraining institutions
- allow government ideology and interests to pre-dominate

Examples of the Play of Ideas, Interests and Institutions

	Interests	Ideas	Institutions
Liberals (1985-90)	Preference to not-for-profit professional providers	De-medicalize home & community care Belief in incremental reform	Lead to MCSS
NDP (1990-95)	Preference to consumers, not-for-profit support providers, labour	De-medicalize home & community care Public engagement & empowerment Belief in the state	Premier's Council Reports Broad consultations Creation of a government agency
PC (1995-2000)	Preference to for-profit providers	Restrict special interest lobby Restrict access to decision maker Belief in competitive markets	Narrow, focused consultation Lead for consultation given to Parliamentary Asst Competitive contracting

Some Conclusions

- Despite discontent with Medicare, the erosion of Canadian publicly funded health care has occurred largely at the margins, e.g., in the home and community care sector.

- In the beginning of the period examined, governments were intent to de-medicalize home care, to remove the requirement of a physician's referral, to provide the health and support services that would enable the elderly and people living with a disability to remain in their homes, thereby avoiding high institutional costs. At the time, reform was largely about providing services to the elderly and the disability community.

- With the onset of recessions, and the restructuring of hospitals, however, home care became the site of the passive privatization of acute care services.

- At the end of the period studied, governments once again medicalized home care, and favoured the substitution function (i.e., pre- and post- hospital discharge care) over the maintenance and prevention functions which enable Ontarians to continue living independently in the community.
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- In response to various commissions, most notably the Romanow Commission, governments have been pressured into recognizing that medically necessary services regardless of the site in which they are provided should be publicly funded. To correct the privatization of acute services, the First Ministers have agreed to provide "first dollar" coverage for a basket of services for short term acute home care.

- The elderly and those living with a chronic illness will once again have to wait their turn for reforms.